

**Attachment D.4.A.3.a.
to Appendix D**

**Family Care
Care Management Organization
Enrollment Form**

II. CMO Enrollment Forms, Continued

(For people enrolling when the CMO is in Phase 3.)

_____ (name of) CMO Enrollment Request Form**Complete the Following: (please print)**

1. First Name:	MI:	Last Name:
2. Phone Number:	Social Security Number:	
3. Street Address:	City:	Zip:
4. Date of Birth:	County of Residence:	
5. Medicaid Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Medicaid Number:		
6. Medicare Number: _____		Effective Date of Part A: _____ Effective Date of Part B: _____

_____ (name of) CMO's Family Care program is explained in the member handbook. I have reviewed the member handbook and understand it. By my signature below I agree that I have been informed of, both verbally and in writing, and understand the following:

- my choices in the CMO and the services available and how to get them;
- my rights and responsibilities as a member of the CMO;
- how to complain and grieve, including my rights to a fair hearing; and
- the providers of services and how to ask for other providers.

I have been informed that all CMO services are furnished under a written plan of care based on the assessment of my health and other needs, and that I will (or have a right to) assist in developing my individual service plan.

I understand that I can voluntarily disenroll from _____ (name of) CMO at any time.

I authorize the disclosure and exchange of information between the CMO and State and Federal oversight agencies or their authorized representatives, including my services and costs.

7. Member Signature:	Date:
8. Guardian Signature:	Date:

9. Assurance of Choice for people who are eligible for Family Care through the Home and Community

Based Waivers: I have been given a choice of receiving services in a nursing home, ICF-MR or in the community through Family Care. By signing below I am saying that I have chosen:

_____ Nursing home or ICF-MR services or _____ Community services through
_____ CMO

Member Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

For Resource Center / CMO Use Only Effective Date of Enrollment: _____ <table> <tr> <td>Medicaid Recipients</td> <td>Non-Medicaid Recipient</td> </tr> <tr> <td><input type="checkbox"/> Intermediate</td> <td><input type="checkbox"/> Intermediate</td> </tr> <tr> <td><input type="checkbox"/> Comprehensive</td> <td><input type="checkbox"/> Comprehensive</td> </tr> </table>	Medicaid Recipients	Non-Medicaid Recipient	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Comprehensive	***For Fiscal Agent Use Only*** Date of Enrollment: _____
Medicaid Recipients	Non-Medicaid Recipient						
<input type="checkbox"/> Intermediate	<input type="checkbox"/> Intermediate						
<input type="checkbox"/> Comprehensive	<input type="checkbox"/> Comprehensive						

Instructions for filling out CMO Enrollment Request

Please print as neatly as possible.

- If you ask, we will give this information in another form, such as Braille, large print or audio tape.
- If you need the assistance of an interpreter, please call the _____ CMO at (_____) _____ - _____, or TDD at (_____) _____ - _____.

Please fill in the following information by numbered line on your enrollment form:

Name:	Write in your name (first name, middle initial, and last name).
Phone Number:	Write in the phone number where you can be reached.
Social Security Number:	Write in your Social Security Number (not your Medicare number). You can find this number on your Social Security card.
Street Address, City and Zip:	Write in where you are currently living.
Date of Birth:	Write in the day you were born including the year.
County of Residence:	Write in the county where you live.
Medicaid Number:	If you are a Medicaid recipient, write in your Medicaid number. This is not always the same as your Social Security number.
Medicare Number:	Write in your Medicare number if you receive Medicare (not your Social Security number). You can find this number on your Medicare card that says "Health Insurance Social Security Act" at the top.
Effective Date of Part A:	On your Medicare card it will say Hospital Insurance with a date after it. Write that date on this line.
Effective Date of Part B:	On your Medicare card it will say Medical Insurance with a date after it. Write that date on this line.
Signature Line:	You must sign and date the bottom of the form.
Signature of Guardian:	If you have a Guardian of the Person, he or she must sign and on this line.
Assurance of Choice:	Sign on this line only if you are both (1) eligible for Medicaid, and (2) eligible for Family Care at the comprehensive level of care. If you have a Guardian of the Person, he or she must also sign here. Staff from the Resource Center can assist you in determining if you need to sign on this line